OKLAHOMA

The following State Evaluation is submitted in compliance with Title XXI of the Social Security Act (Section 2108(b)).

_____

(Signature of Agency Head)

Date: _____

Reporting Period: **December 1, 1997- September 30, 1999**_____

Contact Person/Title: _**Anita Ghosh, Senior Research Specialist**_____

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SECTION 1. SUMMARY OF KEY ACCOMPLISHMENTS OF YOUR CHIP PROGRAM

This section is designed to highlight the key accomplishments of your CHIP program to date toward increasing the number of children with creditable health coverage (Section 2108(b)(1)(A)). This section also identifies strategic objectives, performance goals, and performance measures for the CHIP program(s), as well as progress and barriers toward meeting those goals. More detailed analysis of program effectiveness in reducing the number of uninsured low-income children is given in sections that follow.

1.1 What is the estimated baseline number of uncovered low-income children? Is this estimated baseline the same number submitted to HCFA in the 1998 annual report? If not, what estimate did you submit, and why is it different?

The estimated baseline number of uncovered low-income children is 124,123. It is the same number submitted to HCFA in the 1998 annual report.

1.1.1 What are the data source(s) and methodology used to make this estimate?
See attachment A

1.1.2 What is the State's assessment of the reliability of the baseline estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)
See attachment A

1.2 How much progress has been made in increasing the number of children with creditable health coverage (for example, changes in uninsured rates, Title XXI enrollment levels, estimates of children enrolled in Medicaid as a result of Title XXI outreach, anti-crowd-out efforts)? How many more children have creditable coverage following the implementation of Title XXI? (Section 2108(b)(1)(A))
Oklahoma has had phenomenal success in increasing the number of children with creditable health coverage. On September 30, 1999 we had 30,127 children enrolled in SCHIP and 65,696 additional children enrolled in Medicaid (point in time) as a result of Title XXI outreach.

1.2.1 What are the data source(s) and methodology used to make this estimate?
Medicaid eligibility and enrollment data extracts

1.2.2 What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.) **The data is as reliable as other Medicaid eligibility and enrollment data extracts**.

1.3 What progress has been made to achieve the State's strategic objectives and performance goals for its CHIP program(s)?

Please complete Table 1.3 to summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in the Title XXI State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List the State's strategic objectives for the CHIP program, as specified in the State Plan.

Column 2: List the performance goals for each strategic objective.

Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

For each performance goal specified in Table 1.3, please provide additional narrative discussing how actual performance to date compares against performance goals. Please be as specific as possible concerning your findings to date. If performance goals have not been met, indicate the barriers or constraints. The narrative also should discuss future performance measurement activities, including a projection of when additional data are likely to be available.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
1. Decrease the number of children in the State who lack creditable health insurance coverage.	**By the end of FFY 1998, the State hopes to have forty-five (45%) percent of the newly-eligible uninsured children enrolled, and, by the end of FFY 1999, 75%.**	Data Sources: **Current Population Survey, internal eligibility data, Medicaid enrollment data** Methodology: **Compare number of uninsured enrolled children reported by the system on September 30, 1999 to baseline estimate of uninsured children.** Numerator: **Number of newly-eligible uninsured enrolled children.** Denominator: **Baseline estimate of newly-eligible uninsured children.** Progress Summary: **The State is pleased to report that it enrolled 30,127 (73%) newly-eligible uninsured children by September 30, 1999 (out of 40,995 newly-eligible uninsured children).**
OBJECTIVES RELATED TO CHIP ENROLLMENT		

Table 1.3		
2. Monitor Program participation so that "crowd-out" does not become problematic.	**Survey in the short run to assess crowd-out.**	Data Sources: Methodology: Numerator: Denominator: Progress Summary: **The State will survey enrollees to assess crowd-out in 2000. We do not anticipate finding any evidence of crowd-out since we have expanded coverage up to 185% of the FPL.**
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		

Table 1.3		
3. Increase the enrollment of currently-eligible (but not participating) AFDC and AFDC-related Children in the Medicaid Program.	**Through a statewide outreach effort, the State hopes to increase Medicaid participation by the end of FFY 1998 to 70%, and, by the end of FFY 1999, to 75%.**	Data Sources: **Current Population Survey, internal eligibility data, Medicaid enrollment data** Methodology: **Compare number of enrolled children reported on HCFA 2082 on September 30, 1999 to baseline estimate of eligible children.** Numerator: **Number of Medicaid enrolled children** Denominator: **Baseline estimate of Medicaid eligible children.** Progress Summary: **The State is pleased to report that it enrolled 250,984 (79%) AFDC and AFDC-related children in the Medicaid Program by September 30, 1999 (out of an estimated 317,087 eligible children).**
OTHER OBJECTIVES		

Table 1.3		
4. Ensure that the Medicaid enrollment (participation) percentages are the same for both the rural SoonerCare Choice and urban SoonerCare Plus Programs.	**Cumulative enrollment percentages for the affected urban and rural eligibles will be the same by the end of FFY 1999.**	Data Sources: **Current Population Survey, internal eligibility data, SoonerCare enrollment data** Methodology: **Compare SoonerCare Choice and SoonerCare Plus Programs enrollment data** Numerator: **SoonerCare Choice enrollees and SoonerCare Plus enrollees** Denominator: **SoonerCare Choice eligibles and SoonerCare Plus eligibles** Progress Summary: **At the end of September 1999, approximately 47% of the SoonerCare Plus urban eligibles were enrolled in the program while 67% of the SoonerCare Choice rural eligibles were enrolled in the program.**
OTHER OBJECTIVES		

Table 1.3		
5. Reduce the number of short-term ("medical") enrollments into the Medicaid program which result in periods of retroactive eligibility.	**Reduce such (after-the-fact) enrollments from 90% to (50%) by the end of FFY 1999.**	Data Sources: **Medicaid eligibility data (data extract from Dept. of Human Services).** Methodology: **Count all children with certification dates earlier than application dates and compare with number of all children enrolled.** Numerator: **Number of children with certification dates earlier than application dates and compare with number of all children enrolled.** Denominator: **All children enrolled.** Progress Summary: **The number of short-term ("medical") enrollments into the Medicaid program which result in periods of retroactive eligibility was reduced to 39.44%.**
OTHER OBJECTIVES		

Table 1.3		
6. Minimize the autoassignment rate for newly-enrolled individuals (for both the existing unenrolled eligibles and the new eligibles) in the selection of a PCCM or MCO.	**Enrollment autoassignment rates will be less than (50%) by the end of FFY 1998 and less than 40% by the end of FFY 1999.**	Data Sources: **Medicaid enrollment data** Methodology: **Compare the number of enrollees with the number of children autoassigned** Numerator: **The number of children autoassigned** Denominator: **The number of children enrolled in SoonerCare** Progress Summary: **By September 30, 1999 autoassignment rates were down to 44%.**

III: STRATEGIC OBJECTIVES AND PERFORMANCE GOALS:

1. By the end of FFY 1998, the state hoped to have 75% of the newly eligible uninsured children enrolled (see attachment A for baseline uninsured data estimates/methodology –these were also included in the State Plan as attachment A). Between December 1997 and September 1999, the state is very pleased to report that we have 30,127 SCHIP eligible children enrolled in SoonerCare (at the end of FFY 1998) which is 73% of total SCHIP eligibles.

2. The state is very pleased to report that we have 250,984 AFDC and AFDC-related children enrolled in the Medicaid Program by September 30, 1999 (out of 317,087 eligible children) which brings Oklahoma's participation rate for that population up to approximately 79% (national average was 75%).

3. Due to system constraints, the state was able to identify the children enrolled in the SCHIP only recently. Hence, in FFY 1998 the state has been unable to survey SCHIP enrollees in order to monitor crowd out. Since Oklahoma SCHIP does not cover children over 185% of the Federal Poverty Level, Oklahoma does not anticipate that crowd out will be a significant problem. However the state fully intends to develop several measures aimed at identifying the existence of crowd out. In the short run, Oklahoma has developed a statistically valid survey instrument. The state will survey SCHIP enrollees in order to determine if they dropped private health insurance coverage in the last three months prior to enrollment in SCHIP, and assess the reasons for dropping coverage. Crowd out will be defined as "dropping private health insurance coverage for reasons such as if the employer discontinues coverage, parents voluntarily discontinue coverage for their children due to high premiums for private coverage/better benefits under SCHIP etc". However if health insurance coverage was lost because the parents are no longer employed, or if current employer does not offer insurance etc.- these reasons will not constitute crowd out.

In the long run, the state intends to modify its simplified Medicaid application form in order to collect information necessary to analyze the existence of crowd out. The application form will be modified to incorporate applicable questions from the survey instrument. In addition, in consultation with HCFA, the state will try to define the level of crowd out (maybe as a percentage threshold level) that would trigger any corrective action that HCFA might recommend.

4. Through effective outreach, the state hoped to ensure that the enrollment (participation) percentages are the same for both the rural SoonerCare Choice and urban SoonerCare Plus programs by the end of FFY 1999. Before the expansion (November 1997), there were122,179 enrollees in SoonerCare - 74,170 (39%) enrollees in SoonerCare Plus and 48,009 (37%) enrollees in SoonerCare Choice. After implementing the

expansion (September 1999) the number of enrollees in SoonerCare had increased to 225,840 – 114,949 (47%) enrollees in SoonerCare Plus and 110,891 (67%) enrollees in SoonerCare Choice. As evident from the above numbers, the state is pleased to report that extensive outreach in the SoonerCare Choice areas has already resulted in a considerable increase in the enrollment numbers in those areas. The state will continue to focus it outreach efforts so that the cumulative enrollment percentages for the urban and rural areas will be about the same.

5. Oklahoma is pleased to report that effective outreach has resulted in reductions in after the fact enrollments (retroactive eligibility) from 90% to 39.44% by the end of FFY 1999 (we exceeded our target of reducing it to 50%).

6. Oklahoma is pleased to report that through effective outreach and recipient and eligibility education programs, enrollment autoassignment rates have been reduced to 44% by September 30, 1999. Prior to the expansion autoassignment rates were as high as 88.61%.

SECTION 2. BACKGROUND

This section is designed to provide background information on CHIP program(s) funded through Title XXI.

2.1 How are Title XXI funds being used in your State?

2.1.1 List all programs in your State that are funded through Title XXI. (Check all that apply.)

✓_ Providing expanded eligibility under the State's Medicaid plan (Medicaid CHIP expansion)

Name of program: **___SoonerCare_____**

Date enrollment began (i.e., when children first became eligible to receive services):
__December 1, 1997

___ Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (State-designed CHIP program)

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services):
_____

___ Other - Family Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services):
_____

___ Other - Employer-sponsored Insurance Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services):
_____

___ Other - Wraparound Benefit Package

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services):
_____

___ Other (specify) _____

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services):
_____

2.1.2 **If State offers family coverage:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs. **NA**

2.1.3 **If State has a buy-in program for employer-sponsored insurance:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs. **NA**

2.2 What environmental factors in your State affect your CHIP program?
(Section 2108(b)(1)(E))

2.2.1 How did pre-existing programs (including Medicaid) affect the design of your CHIP program(s)? **The state legislature had expanded Medicaid for the first time in years just a few months before Congress passed CHIP legislation. It was decided to implement CHIP through this Medicaid expansion.**

2.2.2 Were any of the preexisting programs "State-only" and if so what has happened to that program?

✓___ No pre-existing programs were "State-only"

___ One or more pre-existing programs were "State only" ! Describe current status of program(s): Is it still enrolling children? What is its target group? Was it folded into CHIP?

2.2.3 Describe changes and trends in the State since implementation of your Title XXI program that "affect the provision of accessible, affordable, quality health insurance and healthcare for children." (Section 2108(b)(1)(E))

Examples are listed below. Check all that apply and provide descriptive narrative if applicable. Please indicate source of information (e.g., news account, evaluation study) and, where available, provide quantitative measures about the effects on your CHIP program.

_✓__ Changes to the Medicaid program

___ Presumptive eligibility for children
___ Coverage of Supplemental Security Income (SSI) children
___ Provision of continuous coverage (specify number of months ___)
_✓__ Elimination of assets tests
_✓_ Elimination of face-to-face eligibility interviews
_✓__ Easing of documentation requirements **(adopted income declaration instead of income verification from January 1999)**

___ Impact of welfare reform on Medicaid enrollment and changes to AFDC/TANF (specify)_____

___ Changes in the private insurance market that could affect affordability of or accessibility to private health insurance

_✓__ Health insurance premium rate increases
___ Legal or regulatory changes related to insurance
___ Changes in insurance carrier participation (e.g., new carriers entering market or existing carriers exiting market)
_ Changes in employee cost-sharing for insurance
___ Availability of subsidies for adult coverage
___ Other (specify) _____

___ Changes in the delivery system

___ Changes in extent of managed care penetration (e.g., changes in HMO, IPA, PPO activity)
___ Changes in hospital marketplace (e.g., closure, conversion, merger)
___ Other (specify) _____

___ Development of new health care programs or services for targeted low-income children (specify)
_____

___ Changes in the demographic or socioeconomic context

- ___ Changes in population characteristics, such as racial/ethnic mix or immigrant status (specify)_____
- ___ Changes in economic circumstances, such as unemployment rate (specify) _____
- ___ Other (specify)_____
- ___ Other (specify) _____

SECTION 3. PROGRAM DESIGN

This section is designed to provide a description of the elements of your State Plan, including eligibility, benefits, delivery system, cost-sharing, outreach, coordination with other programs, and anti-crowd-out provisions.

3.1 Who is eligible?

3.1.1 Describe the standards used to determine eligibility of targeted low-income children for child health assistance under the plan. For each standard, describe the criteria used to apply the standard. If not applicable, enter "NA."

Table 3.1.1

	Medicaid CHIP Expansion Program	**State-designed CHIP Program**	**Other CHIP Program*** _____ _____ __
Geographic area served by the plan (Section 2108(b)(1)(B)(iv))	**statewide**		
Age	**0 – 17 years**		
Income (define countable income)	**0 - 185% of FPL**		
Resources (including any standards relating to spend downs and disposition of resources)	**Eliminated asset test**		
Residency requirements	**Must be state resident**		
Disability status	**NA**		
Access to or coverage under other health coverage (Section 2108(b)(1)(B)(i))	**Cannot be covered at the time of application**		
Other standards (identify and describe)			

3.1.2 How often is eligibility redetermined?

Table 3.1.2			
Redetermination	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Monthly			
Every six months	**Automatic redetermination (since 1/1/99)**		
Every twelve months			
Other (specify)			

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.1.3 Is eligibility guaranteed for a specified period of time regardless of income changes? (Section 2108(b)(1)(B)(v))

___ Yes ° Which program(s)?

For how long?

_✓__ No

3.1.4 Does the CHIP program provide retroactive eligibility?

__✓_ Yes ° Which program(s)?

How many months look-back? **__90 days**

___ No

3.1.5 Does the CHIP program have presumptive eligibility?

___ Yes ° Which program(s)?

Which populations?

Who determines?

__✓ _ No

3.1.6 Do your Medicaid program and CHIP program have a joint application?

_✓__ Yes ° Is the joint application used to determine eligibility for other State programs?
If yes, specify.
___ No

3.1.7 Evaluate the strengths and weaknesses of your *eligibility determination* process in increasing creditable health coverage among targeted low-income children

The elimination of assets tests, simplified shortened application, elimination of face to face eligibility interviews, and the adoption of income declaration instead of income verification have greatly simplified eligibility determination and reduced barriers to enrollment, thereby improving access to care.

3.1.8 Evaluate the strengths and weaknesses of your *eligibility redetermination* process in increasing creditable health coverage among targeted low-income children. How does the redetermination process differ from the initial eligibility determination process?

Eligibility rules have been revised to establish a new eligibility process that applies specifically to categorically needy pregnant women and families with children that allows an eligibility re-determination process eliminating the automatic case closure at the end of the certification period; and the initial six month eligibility period to consist of the current month and five months forward plus one, two or three months of retroactive eligibility (up to a nine month certification period). Earlier, rules required categorically needy families with children who do not receive cash assistance to be certified for Medicaid for a six-month period. The eligibility period terminated automatically at the end of the six-month period and the case closed without worker action or notice to the client. In order to continue Medicaid coverage, the client had to re-apply. This put the client back into fee-for-service for one to three of the six months of eligibility, thus causing a break in the continuity of care.

The new rules eliminated automatic case closure and replaced the closure with a redetermination process. The eligibility worker has to take an action in order for the case to close. This revision maintains the medical home model for Medicaid clients.
The initial six-month eligibility period usually consisted of 90 days retroactive eligibility in fee-for-service plus three months in Managed Care. The new rules initiate a less burdensome process by allowing the initial certification period to consist of the current month, plus five months forward, plus one, two or three months of retroactive eligibility (up to a nine month certification period).

3.2 What benefits do children receive and how is the delivery system structured? (Section 2108(b)(1)(B)(vi))

3.2.1 Benefits

Please complete Table 3.2.1 for each of your CHIP programs, showing which benefits are covered, the extent of cost sharing (if any), and benefit limits (if any).

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose “select” “table.” Once the table is highlighted, copy it by selecting “copy” in the Edit menu and then “paste” it under the first table.

Table 3.2.1 CHIP Program Type _____			
Benefit	**Is Service Covered? (T = yes)**	**Cost-Sharing (Specify)**	**Benefit Limits (Specify)**
Inpatient hospital services	**T**		
Emergency hospital services	**T**		
Outpatient hospital services	**T**		
Physician services	**T**		
Clinic services	**T**		
Prescription drugs	**T**		
Over-the-counter medications	**T**		**Contraceptive devices and diabetic supplies**
Outpatient laboratory and radiology services	**T**		
Prenatal care	**T**		
Family planning services	**T**		**Tubal ligation for 21 years and older**
Inpatient mental health services	**T**		
Outpatient mental health services	**T**		
Inpatient substance abuse treatment services	**T**		

Residential substance abuse treatment services	**T**		
Outpatient substance abuse treatment services	**T**		
Durable medical equipment	**T**		
Disposable medical supplies	**T**		
Preventive dental services	**T**		
Restorative dental services	**T**		
Hearing screening	**T**		
Hearing aids	**T**		
Vision screening	**T**		
Corrective lenses (including eyeglasses)	**T**		
Developmental assessment	**T**		
Immunizations	**T**		
Well-baby visits	**T**		
Well-child visits	**T**		
Physical therapy	**T**		
Speech therapy	**T**		
Occupational therapy	**T**		
Physical rehabilitation services	**T**		

Podiatric services	**T**		
Chiropractic services	**T**		
Medical transportation	**T**		

Home health services	**T**		
Nursing facility	**T**		**Up to 30 days**
ICF/MR			
Hospice care	**T**		
Private duty nursing	**T**		
Personal care services		**Wrap around (FFS) service**	
Habilitative services	**T**		
Case management/Care coordination	**T**		
Interpreter services	**T**		
Non-emergency transportation	**T**		

3.2.2 Scope and Range of Health Benefits (Section 2108(b)(1)(B)(ii))

Please comment on the scope and range of health coverage provided, including the types of benefits provided and cost-sharing requirements. Please highlight the level of preventive services offered and services available to children with special health care needs. Also, describe any enabling services offered to CHIP enrollees. (Enabling services include non-emergency transportation, interpretation, individual needs assessment, home visits, community outreach, translation of written materials, and other services designed to facilitate access to care.)

CHIP enrollees receive services through two *SoonerCare* programs. *SoonerCare Plus* is a fully-capitated MCO program operating in three urban areas. Rural enrollees receive services through *SoonerCare Choice*, a partially capitated Primary Care Case Management program. The Choice benefit package contains primary care and preventive services (as well as some lab and x-ray). These enrollees may access non-capitated services from fee-for-service providers. A full range of primary care and preventive services is offered. Contracted health plans' Primary Care Physicians and Primary Care Provider/Case Managers in the *SoonerCare Choice* network provide a medical home for each enrollee. Health Plans employ Exceptional Needs Coordinators (ENCs) to assist members with diverse medical needs. ENCs are critical to service delivery for Aged, Blind and Disabled members in addition to others.

As *SoonerCare* members, CHIP enrollees may receive non-emergency transportation, interpretation, individual needs assessment, home visits, community outreach, and translation of written materials and other services designed to facilitate access to care.

3.2.3 Delivery System

Identify in Table 3.2.3 the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Check all that apply.

Table 3.2.3			
Type of delivery system	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
A. Comprehensive risk managed care organizations (MCOs)			
Statewide?	__✓_ Yes ___ No	___ Yes ___ No	___ Yes ___ No
Mandatory enrollment?	__✓_ Yes ___ No	___ Yes ___ No	___ Yes ___ No
Number of MCOs	**4- urban areas**		
B. Primary care case management (PCCM) program	**1- rural areas**		
C. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable)	**none**		

D. Indemnity/fee-for-service (specify services that are carved out to FFS, if applicable)	**1. Long term care services after the 30th day** **2. School-based and Early Intervention services ordered through an IEP, IHSP, 504 Accommodation Plan or IFSP** **3. Tuberculosis follow-up and management** **4. Child Abuse examination services, when furnished out-of-network** **5. Family Planning services for adolescents, when furnished out-of-network** **6. EPSDT screens and immunizations, when furnished out –of-network** **7. Personal Care services, such as assistance with the activities of daily living** **8. Services for IHS beneficiaries,** **9.**		

E. Other (specify)			
F. Other (specify)			
G. Other (specify)			

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.3 How much does CHIP cost families?

3.3.1 Is cost sharing imposed on any of the families covered under the plan? (Cost sharing includes premiums, enrollment fees, deductibles, coinsurance/ copayments, or other out-of-pocket expenses paid by the family.)

___✓ No, skip to section 3.4

___ Yes, check all that apply in Table 3.3.1

Table 3.3.1

Type of cost-sharing	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*_____ _____ _
Premiums			
Enrollment fee			
Deductibles			
Coinsurance/copayments**			
Other (specify) _____			

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

**See Table 3.2.1 for detailed information.

3.3.2 **If premiums are charged:** What is the level of premiums and how do they vary by program, income, family size, or other criteria? (Describe criteria and attach schedule.) How often are premiums collected? What do you do if families fail to pay the premium? Is there a waiting period (lock-out)

before a family can re-enroll? Do you have any innovative approaches to premium collection?

3.3.3 **If premiums are charged:** Who may pay for the premium? Check all that apply. (Section 2108(b)(1)(B)(iii))

___ Employer
___ Family
___ Absent parent
___ Private donations/sponsorship
___ Other (specify) _____

3.3.4 **If enrollment fee is charged:** What is the amount of the enrollment fee and how does it vary by program, income, family size, or other criteria?

3.3.5 **If deductibles are charged:** What is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)?

3.3.6 How are families notified of their cost-sharing requirements under CHIP, including the 5 percent cap?

3.3.7 How is your CHIP program monitoring that annual aggregate cost-sharing does not exceed 5 percent of family income? Check all that apply below and include a narrative providing further details on the approach.

___ Shoebox method (families save records documenting cumulative level of cost sharing)
___ Health plan administration (health plans track cumulative level of cost sharing)
___ Audit and reconciliation (State performs audit of utilization and cost sharing)
___ Other (specify)_____

3.3.8 What percent of families hit the 5 percent cap since your CHIP program was implemented? (If more than one CHIP program with cost sharing, specify for each program.)

3.3.9 Has your State undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what have you found?

3.4 How do you reach and inform potential enrollees?

3.4.1 What client education and outreach approaches does your CHIP program use?

Please complete Table 3.4.1. Identify all of the client education and outreach approaches used by

your CHIP program(s). Specify which approaches are used (**T**=yes) and then rate the effectiveness of each approach on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.1

Approach	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program* _____	
	T = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)
Billboards						
Brochures/flyers	**T**	**5**				
Direct mail by State/enrollment broker/administrative contractor	**T**	**3**				
Education sessions	**T**	**3**				
Home visits by State/enrollment broker/administrative contractor	**T**	**5**				
Hotline	**T**	**5**				
Incentives for education/outreach staff						
Incentives for enrollees						
Incentives for insurance agents						
Non-traditional hours for application intake	**T**	**5**				
Prime-time TV advertisements						
Public access cable TV						

Public transportation ads						
Radio/newspaper/TV advertisement and PSAs	**T**	**2**				
Signs/posters	**T**	**3**				
State/broker initiated phone calls						
Other (specify)						
Other (specify)						

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.4.2 Where does your CHIP program conduct client education and outreach?

Please complete Table 3.4.2. Identify all the settings used by your CHIP program(s) for client education and outreach. Specify which settings are used (**T**=yes) and then rate the effectiveness of each setting on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.2						
Setting	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program* _____	
	T = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)
Battered women shelters	**T**	**4**				
Community sponsored events	**T**	**5**				
Beneficiary's home	**T**	**5**				
Day care centers	**T**	**5**				
Faith communities	**T**	**4**				
Fast food restaurants	**T**	**3**				
Grocery stores	**T**	**3**				
Homeless shelters	**T**	**3**				
Job training centers	**T**	**3**				
Laundromats	**T**	**3**				
Libraries	**T**	**4**				
Local/community health centers	**T**	**4**				
Point of service/provider locations	**T**	**4**				

Public meetings/health fairs	**T**	**4**				
Public housing	**T**	**3**				
Refugee resettlement programs	**T**	**3**				
Schools/adult education sites	**T**	**4**				
Senior centers	**T**	**4**				
Social service agency	**T**	**4**				
Workplace	**T**	**3**				
Other (specify)						
Other (specify)						

Summary of outreach initiatives :

Oklahoma's aggressive outreach initiatives began with the passage of Senate Bill 639 (SB 639) implemented on December 1, 1997. The Oklahoma Health Care Authority, the Department of Human Services, the Oklahoma State Department of Health, and the Oklahoma Commission on Children and Youth collaborated to develop and implement a comprehensive marketing and outreach plan consisting of:

- **Posters,**
- **Postcards,**
- **Public Service Announcements (radio, TV, newspapers),**
- **Fact sheets,**
- **Press releases to mass media (radio, TV, newspapers), and**
- **Flyers.**

Other initiatives that helped increase access and reduce barriers include:

- **Application reduced from 17 pages to 2 (one-page front and back),**

- **Application process time reduced from 45 days to 20 days,**
- **Eliminated face-to-face interview,**
- **Eliminated the asset test,**
- **Eliminated automatic case termination at 6 months and moved to a 6-month re-determination process,**
- **Moved to income declaration,**
- **Applications accessible through the DHS county offices, county health departments, WIC offices, public libraries, school systems, and through the mail by calling a toll-free number.**
- **Special Event: Capitol Media Conference. Provided a brief overview of SB 639. Governor Frank Keating, and House Author Representative Billy Mitchell participated as well as State Agency Heads from the OHCA, the Department of Human Services, Oklahoma Department of Health, and the Oklahoma Commission on Children and Youth.**

1999 Outreach Initiatives:
Statewide Newspaper Promotion - Contract with the Oklahoma Press Association in the development and placement of outreach promotion in 83 "legal" newspapers. Average circulation is 735,188. Total promotional insertions under contract – 14,703,760 (not including in-kind. PSA's and Press releases also provided with paid spots as an "in-kind" contribution by publishers.

Statewide Movie theater advertisements - Contract with Nation Cinema Network for the Placement of Public Service Slide in 27 theaters statewide (127 screens). Average weekly spots shown are 18,375, average weekly attendance is 227,500.

Statewide contract with Oklahoma Broadcasters Association in development of Public Education Partnerships (PEP) spots. Distribution to approximately 130 radio and television stations. Station participation is voluntary. Fixed contract amount with substantial return in exposure verses dollars invested.

Department of Human Services - County by county outreach plans. Innovative approaches to community needs include: increased office hours, outstationed workers, and attendance at special events, community development and awareness including speaking engagements and public school coordination.

A question was added to the Free and Reduced Lunch application for families to check if they wanted more information about *SoonerCare*. The DHS outreach worker is responsible for contacting the schools and gathering this information. They can then send families *SoonerCare* information.

State Fair Booth was manned continually for 17 days in September /October to generate public awareness about *SoonerCare*.

Oklahoma Natural Gas – 750,000 inserts with an article on *SoonerCare* was distributed in February 1999 ONG bills over a 21day period.

Pocket Calendars were developed with the Tulsa Area Coalition on Perinatal care pilot project in Tulsa (20,000). These calendars went to Health Plan new members and to community groups throughout Tulsa.

Coordinated the production of a Smoking Cessation Video (13,000) for pregnant women in collaboration with the Institute for Child Advocacy, Oklahoma State Health Department and the March of Dimes. These videos will be mailed to providers in February 2000.

Wal-Mart in Tulsa agreed to place *SoonerCare* ads on pharmacy bags at no cost to OHCA. These pharmacy bags started being used in November 1999. There have been 189,000 bags delivered to the pharmacies in Tulsa, Broken Arrow, Sand Springs and Owasso. Claremore will start using 24,000 bags in January 2000. Wal-Mart no longer has this "bag program".

Additional Outreach Partnerships:

- **OHCA collaborating with OCCY in the implementation of two rural pilot communities to demonstrate innovative "grass roots" outreach strategies (Stillwater and Ponca City).**
- **OHCA collaborating with the Oklahoma Institute for Child Advocacy in the implementation of the RWJ grant: "The Oklahoma Covering Kids Initiative"**
- **OHCA designated by HCFA as pilot outreach site for its Native American population (Mayes county)**
- **Caring Program for Children through Blue Cross Blue Shield.**
- **Continuation of the State Marketing and Outreach Subcommittee.**

- **OASIS, Information and Referral Service, for children with special needs, infants and toddlers with developmental delays, women, infants, children and adolescents with health care needs has agreed to be the contact for *SoonerCare* outreach worker information for childcare professionals. The Oklahoma Institute for Child Advocacy will be referring childcare providers to OASIS for contact information about their outreach worker.**

<u>Collaborating Agencies/Organizations :</u>

Department of Human Services (DHS)
- **Forty-seven (47) Outreach Workers – February 1999**
- **Individual County Offices**
- **Food Stamp Program**
- **Child Support Program**
- **Day Care Program**

Oklahoma State Department of Health (OSDH)
- **WIC**
- **Head Start**
- **Immunizations**
- **Children's First Program**

Oklahoma Commission on Children and Youth (OCCY)
- **OCCY Grant**

Oklahoma Department of Education (ODE)
- **School Lunch Programs**
- **Oklahoma Parents as Teachers Program**
- **Local School Districts Statewide**
- **21st Century Community Learning Centers (CCLC), project of the Oklahoma City Public Schools**

Oklahoma Institute for Child Advocacy (OICA)

Covering Kids – Robert Wood Johnson Grant

Oklahoma Primary Care Association

Area Health Education Centers (AHECs)
Oklahoma Association of Community Action Agencies
Area Agency on Aging
Oklahoma State Department of Libraries
Oklahoma Office of Minority Health Care Authority
Oklahoma Hospital Association
Oklahoma State University Extension Programs
March of Dimes
Oklahoma Natural Gas (insert)
Walmart (pharmacy bags)
OASIS Information and Referral Service
Tulsa Community Service Council
Caring Program for Children through Blue Cross Blue Shield
Oklahoma Perinatal Coalition
Tulsa Perinatal Coalition

3.4.3 Describe methods and indicators used to assess outreach effectiveness, such as the number of children enrolled relative to the particular target population. Please be as specific and detailed as possible. Attach reports or other documentation where available.

3.4.4 What communication approaches are being used to reach families of varying ethnic backgrounds?

Television, radio, newspaper, county office workers, flyers, postcards, movie advertisements are some of the communication approaches being used to reach families of varying ethnic backgrounds.

3.4.5 Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available.

CAHPS survey results overwhelmingly indicate that the DHS county workers were the most successful in reaching enrollees. However further analysis by ethnic groups reveals that while the DHS county workers were the most successful in reaching all enrollees, Asians preferred to hear about SoonerCare through television, and African Americans, Native Americans, Hispanics, and whites preferred to hear about SoonerCare through the DHS county workers. All the ethnic groups wanted more information, and all groups wanted to hear about new programs through mail.

OHCA Media Questionnaire - CAHPS October 1998 Sample, Analysis by Race

Type of Survey

	Asian		African Amer		Native Amer		Hispanic		White	
	No.	**Pct.**	**No.**	**Pct.**	**No.**	**Pct.**	**No.**	**Pct.**	**No.**	**Pct.**
Adult	**15**	**51.7**	**349**	**45.4**	**88**	**40.6**	**39**	**31.0**	**704**	**45.7**
Child	**14**	**48.3**	**419**	**54.6**	**129**	**59.5**	**87**	**69.1**	**838**	**54.4**
Total	**29**	**100**	**768**	**100**	**217**	**100**	**126**	**100**	**1542**	**100**

Note: Percent columns are rounded to nearest whole number.

	Asian		African Amer		Native Amer		Hispanic		White	

	No.	Pct.	No.	Pct.	No.	Pct.	No.	Pct.	No.	Pct.
Female	**21**	**72.4**	**555**	**72.3**	**148**	**68.2**	**86**	**68.3**	**1109**	**71.9**
Male	**8**	**27.6**	**213**	**27.7**	**69**	**31.8**	**40**	**31.8**	**433**	**28.1**
Total	**29**	**100**	**768**	**100**	**217**	**100**	**126**	**100**	**1542**	**100**

Note: Percent columns are rounded to nearest whole number.

	Asian		African Amer		Native Amer		Hispanic		White	
	No.	**Pct.**	**No.**	**Pct.**	**No.**	**Pct.**	**No.**	**Pct.**	**No.**	**Pct.**
Blue Lincs	**9**	**31.0**	**158**	**20.6**	**26**	**12.0**	**19**	**15.1**	**335**	**21.7**
Community Care	**11**	**37.9**	**135**	**17.6**	**35**	**16.1**	**24**	**19.1**	**274**	**17.8**
Heartland	**4**	**13.8**	**190**	**24.7**	**34**	**15.7**	**28**	**22.2**	**266**	**17.3**
Prime Advantage	**5**	**17.2**	**203**	**26.4**	**59**	**27.2**	**39**	**31.0**	**205**	**13.3**
Sooner Choice	**0**	**0.0**	**82**	**10.7**	**63**	**29.0**	**16**	**12.7**	**462**	**30.0**
Total	**29**	**100**	**768**	**100**	**217**	**100**	**126**	**100**	**1542**	**100**

Note: Percent columns are rounded to nearest whole number.

How did you hear about SoonerCare?

	Asian		African Amer		Native Amer		Hispanic		White	
	No.	Pct.	No.	Pct.	No.	Pct.	No.	Pct.	No.	Pct.
TV	0	0.0	91	11.9	25	11.5	15	11.9	135	8.8
Radio	0	0.0	13	1.7	3	1.4	3	2.4	23	1.5
Newspaper	1	3.5	19	2.5	5	2.3	5	4.0	24	1.6
County Offc	11	37.9	519	67.6	142	65.4	73	57.9	1081	70.1
Flyer	2	6.9	37	4.8	15	6.9	9	7.1	70	4.5
Postcard	2	6.9	26	3.4	10	4.6	9	7.1	53	3.4
Movie	0	0.0	3	0.4	1	0.5	0	0.0	5	0.3
Friend	2	6.9	92	12.0	19	8.8	20	15.9	183	11.9
Family	5	17.2	66	8.6	19	8.8	14	11.11	156	10.1
School	0	0.0	9	1.2	4	1.8	2	1.6	15	1.0
Library	0	0.0	0	0.0	1	0.5	0	0.0	2	0.1
Other	8	27.6	107	13.9	51	23.5	19	15.1	271	17.6

Note: Percent columns are rounded to nearest whole number.

How many times did you hear about SoonerCare?

	Asian		African Amer		Native Amer		Hispanic		White	
	No.	Pct.	No.	Pct.	No.	Pct.	No.	Pct.	No.	Pct.
No Response	0	0.0	28	3.7	4	1.8	1	0.8	27	1.8
Never	2	6.9	91	11.9	32	14.8	16	12.7	223	14.5
1-5 Times	21	72.4	430	56.0	124	57.1	69	54.8	942	61.1
6-10 Times	2	6.9	86	11.2	26	12.0	15	12.0	138	9.0
More than 10 Times	4	13.8	133	17.3	31	14.3	25	19.8	212	13.8
Total	29	100	768	100	217	100	126	100	1542	100

Note: Percent columns are rounded to nearest whole number.

How do you like to hear about SoonerCare?

	Asian		African Amer		Native Amer		Hispanic		White	
	No.	Pct.	No.	Pct.	No.	Pct.	No.	Pct.	No.	Pct.
No Response	2	6.9	110	14.3	30	13.8	17	13.5	215	13.9
TV	9	31.0	95	12.4	28	12.9	21	16.7	161	10.4
Radio	0	0.0	9	1.2	2	1.0	0	0.0	11	0.7
Newspaper	0	0.0	6	0.8	1	0.5	1	0.8	11	0.7
Movie	0	0.0	0	0.0	0	0.0	0	0.0	3	0.2
County Offc	8	27.3	350	45.6	89	41.0	49	38.9	742	48.1
Flyer	1	3.5	34	4.4	14	6.5	4	3.2	66	4.3
Postcard	3	10.3	18	2.3	6	2.8	4	3.2	22	1.4
Friend	1	3.5	29	3.8	9	4.2	7	5.6	67	4.4
Family	1	3.5	25	3.3	9	4.2	5	4.0	58	3.8
School	0	0.0	0	0.0	2	1.0	1	0.8	9	0.6
Library	0	0.0	0	0.0	0	0.0	0	0.0	2	0.1
Other	4	13.8	92	12.0	27	12.4	17	13.5	175	11.4
Total	29	100	768	100	217	100	126	100	1542	100

Note: Percent columns are rounded to nearest whole number.

Did you want more information?

	Asian		African Amer		Native Amer		Hispanic		White	
	No.	Pct.	No.	Pct.	No.	Pct.	No.	Pct.	No.	Pct.
No Response	3	10.3	43	5.6	16	7.4	7	5.6	93	6.0
Yes	20	69.0	357	46.5	109	50.2	67	53.2	780	50.6

No	**6**	**20.7**	**368**	**47.9**	**92**	**42.4**	**52**	**41.3**	**669**	**43.4**
Total	**29**	**100**	**768**	**100**	**217**	**100**	**126**	**100**	**1542**	**100**

Note: Percent columns are rounded to nearest whole number.

How do you want to hear about new programs?

	Asian		African Amer		Native Amer		Hispanic		White	
	No.	Pct.	No.	Pct.	No.	Pct.	No.	Pct.	No.	Pct.
No Response	2	6.9	95	12.4	20	9.2	12	9.5	183	11.9
TV/Radio	5	17.2	112	14.6	32	14.8	18	14.3	194	12.6
Word of Mouth	2	6.9	106	13.8	37	17.1	23	18.3	297	19.3
Mail	20	69.0	455	59.2	128	59.0	73	57.9	868	56.3
Total	29	100	768	100	217	100	126	100	1542	100

Note: Percent columns are rounded to nearest whole number.

3.5 What other health programs are available to CHIP eligibles and how do you coordinate with them? (Section 2108(b)(1)(D))

Describe procedures to coordinate among CHIP programs, other health care programs, and non-health care programs. Table 3.5 identifies possible areas of coordination between CHIP and other programs (such as Medicaid, MCH, WIC, School Lunch). Check all areas in which coordination takes place and specify the nature of coordination in narrative text, either on the table or in an attachment.

Table 3.5

Type of coordination	Medicaid*	Maternal and child health	Other (specify) _____	Other (specify) _____
Administration				
Outreach				
Eligibility determination				
Service delivery				
Procurement				
Contracting				
Data collection				
Quality assurance				
Other (specify)				
Other (specify)				

*Note: This column is not applicable for States with a Medicaid CHIP expansion program only.

3.6 How do you avoid crowd-out of private insurance?

3.6.1 Describe anti-crowd-out policies implemented by your CHIP program. If there are differences across programs, please describe for each program separately. Check all that apply and describe.

____Eligibility determination process:

___ Waiting period without health insurance (specify)
___ Information on current or previous health insurance gathered on application (specify)
___ Information verified with employer (specify)
___ Records match (specify)
___ Other (specify)
___ Other (specify)

___ Benefit package design:

___ Benefit limits (specify)
___ Cost-sharing (specify)
___ Other (specify)
___ Other (specify)

___ Other policies intended to avoid crowd out (e.g., insurance reform):

___ Other (specify)
___ Other (specify) _____

3.6.2 How do you monitor crowd-out? What have you found? Please attach any available reports or other documentation.

SECTION 4. PROGRAM ASSESSMENT

This section is designed to assess the effectiveness of your CHIP program(s), including enrollment, disenrollment, expenditures, access to care, and quality of care.

4.1 Who enrolled in your CHIP program?

4.1.1 What are the characteristics of children enrolled in your CHIP program? (Section 2108(b)(1)(B)(i))

Please complete Table 4.1.1 for each of your CHIP programs, based on data from your HCFA quarterly enrollment reports. Summarize the number of children enrolled and their characteristics. Also, discuss average length of enrollment (number of months) and how this varies by characteristics of children and families, as well as across programs.

States are also encouraged to provide additional tables on enrollment by other characteristics, including gender, race, ethnicity, parental employment status, parental marital status, urban/rural location, and immigrant status. Use the same format as Table 4.1.1, if possible.

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose "select" "table." Once the table is highlighted, copy it by selecting "copy" in the Edit menu and then "paste" it under the first table.

NOTE: Income information is not available for FFY 1998.

Table 4.1.1 CHIP Program Type _____

Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	**17,554**	**41,895**	**2.38**	**2.49**	**3,315**	**4,814**
Age						
Under 1	**959**	**1,347**	**2.35**	**2.46**	**100**	**119**
1-5	**4,454**	**9,688**	**2.38**	**2.46**	**866**	**1,291**
6-12	**10,015**	**20,825**	**2.41**	**2.50**	**1,898**	**2,307**
13-18	**2,126**	**10,035**	**2.39**	**2.52**	**451**	**1,097**
Countable Income Level*						

At or below 150% FPL		**32,471**		**2.47**		**4,055**
Above 150% FPL		**9,424**		**2.52**		**759**
Age and Income						
Under 1						
At or below 150% FPL		**536**		**2.46**		**73**
Above 150% FPL		**811**		**2.47**		**46**
1-5						
At or below 150% FPL		**6,716**		**2.43**		**1,038**
Above 150% FPL		**2,972**		**2.51**		**253**
6-12						
At or below 150% FPL		**17,212**		**2.51**		**2,031**
Above 150% FPL		**3,613**		**2.56**		**276**
13-18						
At or below 150% FPL		**8,007**		**2.51**		**913**
Above 150% FPL		**2,028**		**2.56**		**184**
Type of plan						
Fee-for-service	**5,918**	**10,883**	**1.98**	**1.96**	**400**	**1,381**
Managed care	**6,762**	**18,496**	**2.6**	**2.75**	**1,706**	**2,114**
PCCM	**4,874**	**12,516**	**2.57**	**2.75**	**1,209**	**1,319**

*Countable Income Level is as defined by the states for those that impose premiums at defined levels other than 150% FPL. See the HCFA Quarterly Report instructions for further details.

SOURCE: HCFA Quarterly Enrollment Reports, Forms HCFA-21E, HCFA-64.21E, HCFA-64EC, HCFA Statistical Information Management System, October 1998

4.1.2 How many CHIP enrollees had access to or coverage by health insurance prior to enrollment in CHIP? Please indicate the source of these data (e.g., application form, survey). (Section 2108(b)(1)(B)(i))

The State will survey enrollees to assess crowd-out in 2000. We do not anticipate finding any evidence of crowd-out since we have only expanded coverage up to 185%

of the FPL.

4.1.3 What is the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children? (Section 2108(b)(1)(C))

4.2 Who disenrolled from your CHIP program and why?

4.2.1 How many children disenrolled from your CHIP program(s)? Please discuss disenrollment rates presented in Table 4.1.1. Was disenrollment higher or lower than expected? How do CHIP disenrollment rates compare to traditional Medicaid disenrollment rates?

Before implementation of SCHIP, .6% of TANF cases were closed due to death, resources, medical, procedural reasons, 26.35% of TANF cases were closed due to income related reasons, 51.7% of TANF cases were closed due to eligibility related reasons, and 21.4% of TANF cases were closed due to other reasons.

4.2.2 How many children did not re-enroll at renewal? How many of the children who did not re-enroll got other coverage when they left CHIP?

The state currently does not track this data requirement.

4.2.3 What were the reasons for discontinuation of coverage under CHIP? (Please specify data source, methodologies, and reporting period.)

Table 4.2.3

Reason for discontinuation of coverage	Medicaid CHIP Expansion Program		State-designed CHIP Program		Other CHIP Program* _____	
	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total
Total	**4,814**					
Access to commercial insurance						
Eligible for Medicaid	**46**	**.96%**				
Income too high						
Aged out of program	**22**	**.45%**				
Moved/died	**27**	**.56%**				
Nonpayment of premium						
Incomplete documentation	**2**	**.03%**				
Did not reply/unable to contact	**4,223**	**87.72%**				
Other (specify) **Divorced/separated/left home**	**104**	**2.17%**				
Other (specify)						
Don't know **May have moved**	**389**	**8.08%**				

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

The above number of disenrollees represents the number of disenrollees in the quarter ending September 30, 1999. This data was obtained from The Department of Human Services eligibility records.

4.2.4 What steps is your State taking to ensure that children who disenroll, but are still eligible, re-enroll?

Some counties are initiating follow-up contact with individuals who have disenrolled . Also, eligibility rules have been revised to establish a new eligibility process that applies specifically to categorically needy pregnant women and families with children. The eligibility re-determination process eliminates the automatic case closure at the end of the certification period; and replaces the closure with a redetermination process. It is expected that there will be fewer disenrollments as a result of this rule revision.

4.3 How much did you spend on your CHIP program?

4.3.1 What were the total expenditures for your CHIP program in federal fiscal year (FFY) 1998 and 1999?

FFY 1998 **___$6,200,447_____**

FFY 1999 ___$19,652,304_____

Please complete Table 4.3.1 for each of your CHIP programs and summarize expenditures by purchasing private health insurance premiums versus purchasing direct services?

Table 4.3.1 CHIP Program Type _____

Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures	**6,200,447**	**19,652,304**	**4,920,675**	**15,641,269**
Premiums for private health insurance (net of cost-sharing offsets)*	**1,848,742**	**7,239,957**	**1,467,162**	**576,282**
Fee-for-service expenditures (subtotal)				
Inpatient hospital services	**1,316,644**	**2,425,478**	**1,044,889**	**1,930,438**
Inpatient mental health facility services	**544,787**	**2,251,190**	**432,343**	**1,791,722**
Nursing care services				
Physician and surgical services	**451,442**	**1,196,707**	**358,264**	**952,459**

Outpatient hospital services	**339,583**	**880,913**	**269,493**	**701,119**
Outpatient mental health facility services	**60,405**	**107,368**	**47,937**	**85,454**
Prescribed drugs	**510,618**	**1,859,163**	**405,226**	**1,479,708**
Dental services	**374,947**	**1,033,099**	**297,558**	**822,243**
Vision services	**153,728**	**408,772**	**121,999**	**325,342**
Other practitioners' services	**375,963**	**1,617,396**	**298,364**	**1,287,285**
Clinic services	**55,750**	**125,324**	**44,243**	**99,745**
Therapy and rehabilitation services	**3,187**	**6,348**	**2,529**	**5,052**
Laboratory and radiological services	**61,595**	**159,957**	**48,882**	**127,310**
Durable and disposable medical equipment	**11,193**	**67,894**	**8,883**	**54,037**
Family planning				
Abortions				
Screening services	**45,355**	**82,168**	**35,994**	**65,398**
Home health	**4,534**	**10,850**	**3,598**	**8,636**
Home and community-based services		**2,925**		**2,328**
Hospice				
Medical transportation	**21,600**	**36,550**	**17,142**	**29,090**
Case management	**16,319**	**128,078**	**12,951**	**101,937**
Other services	**4,055**	**12,167**	**3,218**	**9, 684**

4.3.2 What were the total expenditures that applied to the 10 percent limit? Please complete Table 4.3.2 and summarize expenditures by category.

What types of activities were funded under the 10 percent cap?_____**NA**_____

What role did the 10 percent cap have in program design? _____**NA**_____

Table 4.3.2

Type of expenditure	Medicaid Chip Expansion Program		State-designed CHIP Program		Other CHIP Program* _____	
	FY 1998	FY 1999	FY 1998	FY 1999	FY 1998	FY 1999
Total computable share						
Outreach						
Administration						
Other_____						
Federal share						
Outreach						
Administration						
Other __ _____						

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.3.3 What were the non-Federal sources of funds spent on your CHIP program (Section 2108(b)(1)(B)(vii))

_✓__ State appropriations
___ County/local funds
___ Employer contributions
___ Foundation grants
___ Private donations (such as United Way, sponsorship)
___ Other (specify) _____

4.4 How are you assuring CHIP enrollees have access to care?

4.4.1 What processes are being used to monitor and evaluate access to care received by CHIP enrollees? Please specify each delivery system used (from question 3.2.3) if approaches vary by the delivery system within each program. For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in a Primary Care Case Management program, specify 'PCCM.'

Table 4.4.1

Approaches to monitoring access	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Appointment audits			
PCP/enrollee ratios			
Time/distance standards			
Urgent/routine care access standards			
Network capacity reviews (rural providers, safety net providers, specialty mix)			
Complaint/grievance/ disenrollment reviews			
Case file reviews	**QARI Standard 12 (HMO and PCCM program)**		
Beneficiary surveys	**CAHPS (HMO and PCCM program)**		
Utilization analysis (emergency room use, preventive care use)	**HEDIS (HMO only) Focused Studies on EPSDT, Immunizations, and Pediatric Asthma (HMO and PCCM program) Pregnancy and Birth Outcomes (HMO only)**		
Other (specify) _____			
Other (specify) _____			
Other (specify) _____			

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a

table, right click on the mouse, select “insert” and choose “column”.

4.4.2 What kind of managed care utilization data are you collecting for each of your CHIP programs? If your State has no contracts with health plans, skip to section 4.4.3.

Table 4.4.2

Type of utilization data	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Requiring submission of raw encounter data by health plans	_✓__ Yes ___ No	___ Yes ___ No	___ Yes ___ No
Requiring submission of aggregate HEDIS data by health plans	__✓_ Yes ___ No	___ Yes ___ No	___ Yes ___ No
Other (specify)_____	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.4.3 What information (if any) is currently available on access to care by CHIP enrollees in your State? Please summarize the results.

HEDIS data are available on access to care for three years of data collection from participating plans. Data indicate continued improvement reflecting both improvement in services received and improvement in documentation.

4.4.4 What plans does your CHIP program have for future monitoring/evaluation of access to care by CHIP enrollees? When will data be available?

OHCA has adopted QISMC as a monitoring tool for the current contract year. QARI had been used previously. QISMC data will be collected in the spring of 2000. HEDIS data will continue to be collected and reported by plans for all Medicaid measures.

4.5 How are you measuring the quality of care received by CHIP enrollees?

4.5.1 What processes are you using to monitor and evaluate quality of care received by CHIP enrollees, particularly with respect to well-baby care, well-child care, and immunizations? Please specify the approaches used to monitor quality within each delivery system (from question 3.2.3). For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in primary care case management, specify 'PCCM.'

Table 4.5.1

Approaches to monitoring quality	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program
Focused studies (specify)	**Focused Studies on EPSDT, Immunizations, and Pediatric Asthma (HMO and PCCM program) Pregnancy and Birth Outcomes (HMO only)**		
Client satisfaction surveys	**CAHPS (HMO and PCCM program)**		
Complaint/grievance/ disenrollment reviews			
Sentinel event reviews			
Plan site visits	**QARI (HMO and PCCM program)**		
Case file reviews	**QARI Standard 12 (HMO and PCCM program)**		
Independent peer review	**The State's EQRO is the Oklahoma Foundation for Medical Quality (OFMQ). OFMQ has conducted QARI Reviews, Focused Studies, and CAHPS Surveys.**		

HEDIS performance measurement	**Medicaid HEDIS Measures have been collected and reported by plans for three years, 1997, 1998, and 1999.**		
Other performance measurement (specify)			
Other (specify) _____			
Other (specify) _____			
Other (specify) _____			

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.5.2 What information (if any) is currently available on quality of care received by CHIP enrollees in your State? Please summarize the results.

Data from QARI has been collected for four years. Data indicates a continued improvement across all measures for the years collected. Two health plans with national accreditation do show a decline in certain measures. This is due to the utilization of more stringent national accreditation scores for QARI measures rather that the State collected measures. Results for the specific QARI measures are summarized in the attached QARI Executive Summary.

Data from CAHPS Surveys has been collected for two years. CAHPS surveys have been conducted in Oklahoma since its availability and Oklahoma was a pilot site for the development of the Medicaid CAHPS Survey. The results indicate a continued increase in satisfaction levels across the years CAHPS has been conducted. This is summarized in the attached CAHPS article submitted for publication in the Oklahoma State Medical Association Journal.

Data from focused studies has also been collected for four years. The data indicate a continued improvement in services and the documentation needed to produce results. The most recent EPSDT data resulting from the EPSDT Focused Study indicate not only improved rated, but rates exceeding the state EPSDT rate reported on the HCFA 416. Since the focused study rates are determined from actual medical records reviews rather than claim or encounter data, this indicates that EPSDT rates are higher than the State is able to document on standard 416 reporting criteria. The results of the EPSDT, Immunization, Asthma, and Pregnancy and Birth Outcomes focused studies are attached.

HEDIS data have been collected for Medicaid measures by HMOs for three years, 1997 (for calendar year 1996), 1998 (for calendar year 1997) and

1999(for calendar year 1998). These data are reflective of the overall ability to collect documentation for services as well as the services themselves. While Oklahoma health plans participating in Medicaid have improved in the ability to collect appropriate data, work remains. Oklahoma is a new state to the HMO market and data analysis tools remain behind national norms. HEDIS data collected by the plans indicate an overall improvement in services. The most current HEDIS documentation is attached.

4.5.3 What plans does your CHIP program have for future monitoring/evaluation of quality of care received by CHIP enrollees? When will data be available?

OHCA has adopted QISMC as a monitoring tool for the current contract year. QARI had been used previously. QISMC data will be collected in the spring of 2000. In keeping with QISMC direction, the HMOs will conduct focused studies, Quality Improvement Projects (QIP) under QISMC. The State has selected an EPSDT study as the State sponsored QIP under QISMC. The plans will select one other QIP. QIP studies are two years in duration rather than the one-year focused studies. Study design and baseline data collection will be documented in the spring of 2000, with actual study outcomes in the spring of 2001.

The CAHPS survey process will also be the responsibility of the HMOs, in keeping with NCQA direction. CAHPS data will be available in the Summer of 2000. Data will be aggregated and submitted by the State to the National CAHPS Benchmarking Database.

HEDIS data will continue to be submitted to the State and will be available for HEDIS 2000 (calendar year 1999) in the summer of 2000.

4.6 Please attach any reports or other documents addressing access, quality, utilization, costs, satisfaction, or other aspects of your CHIP program's performance. Please list attachments here.

QARI Executive Summary
Focused Studies Summary
CAHPS Article
HEDIS Data Tables

SECTION 5. REFLECTIONS

This section is designed to identify lessons learned by the State during the early implementation of its CHIP program as well as to discuss ways in which the State plans to improve its CHIP program in the future. The State evaluation should conclude with recommendations of how the Title XXI program could be improved.

5.1 What worked and what didn't work when designing and implementing your CHIP program? What lessons have you learned? What are your "best practices"? Where possible, describe what evaluation efforts have been completed, are underway, or planned to analyze what worked and what didn't work. Be as specific and detailed as possible. (Answer all that apply. Enter 'NA' for not applicable.)

5.1.1 Eligibility Determination/Redetermination and Enrollment

5.1.2 Outreach

5.1.3 Benefit Structure

One of the compelling reasons for implementing SCHIP through a Medicaid expansion was the comprehensive benefit package for children. Oklahoma's Medicaid benefit package, including services covered through EPSDT, is as extensive a benefit package as could be offered.

5.1.4 Cost-Sharing (such as premiums, copayments, compliance with 5% cap)

NA

5.1.5 Delivery System

5.1.6 Coordination with Other Programs (especially private insurance and crowd-out)

5.1.7 Evaluation and Monitoring (including data reporting)

5.1.8 Other (specify)

5.2 What plans does your State have for "improving the availability of health insurance and health care for children"? (Section 2108(b)(1)(F))

5.3 What recommendations does your State have for improving the Title XXI program? (Section 2108(b)(1)(G))

Oklahoma realizes that SCHIP presents a historic opportunity to reduce the significant number of uninsured children in the state. However some provisions of SCHIP make it difficult for the state to successfully implement it. The Federal allotment under SCHIP (in the initial years) is based on the numbers of uninsured children in the states at or below 200% of the Federal Poverty Level. However if an uninsured child is eligible for Medicaid, he/she is required to be enrolled in Medicaid and is ineligible for SCHIP. Therefore states with high numbers of prior Medicaid eligible uninsured children (like Oklahoma) will never be able to access all of their federal allotment in order to enroll this traditionally hard to reach population; at the same time SCHIP holds states accountable for enrolling them.

Hence, one of the biggest obstacles that Oklahoma will face in accessing all the SCHIP funds is that most of the uninsured children in the state are eligible for Medicaid and thereby ineligible for coverage under SCHIP. Our enrollment numbers confirm our concerns that even after spending the maximum federal SCHIP funds on administrative

costs (including outreach), Oklahoma is going to have great difficulty in spending its federal allotment. It would be our recommendation that the use of SCHIP allotments be extended to cover Medicaid eligible children, because the promotion of SCHIP will bring additional Medicaid eligible children onto the rolls. As a result some states may have no incentive to increase outreach efforts. If the higher SCHIP rates were available to states that successfully enroll new children into either Medicaid or SCHIP, states could adopt more effective outreach programs without fear of harming their budgets.

ATTACHMENT A

OVERVIEW

SENATE BILL 639 EXPANSION
PHASE I
ESTIMATES OF POTENTIAL ELIGIBLES/PARTICIPANTS

(Up to 185% of the Federal Poverty Level - Ages 0 Through 17)

ESTIMATES OF POTENTIAL ELIGIBLES/PARTICIPANTS IN THE MEDICAID EXPANSION - PHASE I

(Up to 185% of the Federal Poverty Level - Ages 0 Through 17)

Introduction:

Phase I of State Senate Bill (S.B.) 639, passed during the 1997 Legislative Session, directed the Oklahoma Health Care Authority (OHCA) to expand Medicaid eligibility for pregnant women and for children under age eighteen (18) years from their current levels up to 185% of the Federal Poverty Level (FPL). The expansion will begin December 1, 1997 and will continue over a three (3) year period. Children 15 through 17 years of age are to be added by age cohort, in each subsequent year. Therefore, 15 year olds will be eligible at 185% of FPL on October 1, 1998, 16 year olds October 1, 1999 and 17 year olds in the year 2000. Enrollment of 16 and 17 year olds was accelerated on November 1, 1998.

In order to develop policies for future Medicaid expansions, States face the daunting task of obtaining reliable data. The OHCA undertook a systematic survey of the available data and developed a methodology to estimate: the number of potential new Medicaid eligibles under S.B. 639 expansion (95,114), the number of current Medicaid eligibles who are not enrolled (104,853), and the number of "uninsured new and current" Medicaid eligibles (124,143). The following sections outline the State's data sources and methodology (including assumptions) utilized in development of its estimates. Special attention should be directed to the limitations inherent in the interpretation of such estimates.

Data sources:

The primary data sources for the estimates are the US Census Bureau's Current Population Survey (CPS) 1994-96, the FFY 1997 HCFA 2082 data (through August 31,1997), the Urban Institute's *State-level Databook on Health Care Access and Financing published in 1995*, which provides valuable information on health systems at the state level (1990-93 data), and county-specific focus studies of general population estimates of age/sex/poverty conducted by the Oklahoma Department of Commerce (1994).

The CPS is an important source of information on the health insurance coverage of Americans, and also provides data on work status, income, demographic characteristics, and other family and individual characteristics. However, the sample size for a given state can be relatively small, resulting in less reliable estimates of population characteristics at the state level. In addition, samples in states may be drawn from limited areas (often urban centers) which may not be representative of the state's entire population. Concerns have also been raised that the CPS does not directly capture coverage under special state-funded programs or the Indian Health Service, it under-reports Medicaid coverage, receives inconsistent answers to different questions, and may reflect information provided by the survey respondents at the time of the interview rather than during the previous year. In spite of the above limitations, the CPS is, in fact, the

only available source of reliable estimates of the uninsured population at the state level.

The HCFA 2082 form contains state-level data on Medicaid enrollees, reason for eligibility, type of medical services provided, and expenditure amounts. Concerns about the quality of the HCFA 2082 data include under-reporting for certain enrollment groups or medical services, several 209(b) states categorizing most of their SSI disabled populations as non-cash recipients, and patterns of expenditures that exhibit large deviations from those of the past (or future).

The Urban Institute's *State-level Databook on Health Care Access and Financing* published in 1995, provides valuable information on health systems at the state level (1990-93 data). The distribution of 1995 uninsured data is based on the county-specific focus studies of general population estimates of age/sex/poverty by the Oklahoma Department of Commerce (1994). In all cases the most current available data are presented.

Methodology:

Population - Analyses of the most current Census data (1996) suggest that there are approximately 880,796 children under age 18 and 928,503 children under age 19 in the state of Oklahoma. Since Phase I of S.B. 639 expands Medicaid coverage to all children in the state whose family income does not exceed 185% of the federal poverty level (FPL), and who are required to be covered at 100% of the FPL pursuant to federal requirements, these estimates of potential participants in the Medicaid expansion is computed from the estimated 928,503 children under age 19 (see Exhibit I below).

Exhibit I
1996 Population Estimates

Under 1	44,233	
1-5	231,786	
6-14	449,114	
15-17	155,663	
Total		**880,796**
18	47,707	
Total		**928,503**

Eligibles - Due to lack of current information on the distribution of the 1996 population by age and income, historical 1995 distribution of the population by age and income was utilized to estimate the number of eligibles for the expansion. Approximately 48% of the population has income below 185% of FPL. The total eligibles were separated into two distinct populations:

1) Medicaid eligibles under new income and resource guidelines as of December 1, 1997 (new Medicaid eligibles), and
2) Medicaid eligibles who could meet income and resource guidelines in effect as of November 30, 1997 (current Medicaid eligibles).

Our calculations show that approximately 95,114 new children under the age of 18 whose family income does not exceed 185% of the FPL may be eligible for the expansion (See Exhibit II below).

Exhibit II
Estimates of Total Eligibles

Total Children 0 through 17	880,796	
Age and income factor	x .48	
Total with income below 185% of FPL		**422,782**
Total Children 0 through 17	880,796	
Eligibility factor [1]	x .36	
Current Medicaid Eligibles (Total who meet income/resource guidelines in effect as of November 30, 1997 enrolled/unenrolled)		**317,087**
Total w/income below 185% of FPL	422,782	
Less: November 1997 Eligibles	(317,087)	
Less: Blind Disabled	(10,581)	
New Medicaid Eligibles (Total new eligibles who meet income/resource guidelines enrolled/unenrolled as of December 1, 1997)		**95,114**

Medicaid Enrollment "Outreach" - Next the OHCA attempted to identify the target population of eligible children who may be unaware of the availability of health insurance who meet income and resource guidelines in effect as of November 30, 1997 but are not enrolled in the program (see Exhibit III below). The annualized number of unduplicated eligible children (212,234) who were enrolled in the Medicaid program at least one month during federal fiscal year 1997 (as per HCFA 2082 through August 31, 1997) was deducted from the total number of current Medicaid eligibles (317,087). Since the Urban Institute data did not include blind/disabled enrolled children, a small adjustment was made to the HCFA 2082 data to ensure that our data remains comparable. Our results reveal that there may be 104,853 children in the state who are currently Medicaid eligible but not enrolled in the program (approximate participation rate of 66.9%).

[1] A historical eligibility factor of 36% (based on the most current available data published by the Urban Institute in 1995) was used to estimate the total number of children who could meet eligibility standards as of November 30, 1997.

Exhibit III
Medicaid Eligibles Not Enrolled Under Income and Resource Guidelines
In Effect as of November 30, 1997

Total Current Medicaid Eligibles	317,087
Medicaid Enrolled (Net of Blind, Disabled)	(212,234)
Participation Rate (Enrolled/Eligibles)	66.9%
Medicaid Eligibles Not Enrolled "Outreach Group"	**104,853**

When this *outreach group* of 104,853 is added to the 95,114 new Medicaid eligibles under the December 1, 1997 income and resource guidelines, the total pool of Medicaid eligibles under 185% of the FPL equals 199,967.

Health Insurance Status - Next the OHCA attempted to determine the number of **"**uninsured" from the pool of 199,967 eligibles with incomes below 185% of the FPL (see Exhibit IV below). A historical insurance factor of .207 percent was used for the *outreach group* (current Medicaid eligibles not enrolled) and an insurance factor of .569 percent was used to estimate the number of uninsured *new eligibles* (based on the most current available data published by the Urban Institute in 1995 for family insurance coverage across income levels). Of the outreach group, 21,705 of the 104,853 may have some form of insurance, and of the new eligibles 54,120 of the 95,114 may have some form of insurance.

Exhibit IV
Estimated Uninsured[2]

Medicaid Eligibles "Outreach"	*104,853*
Insurance Factor	x .207

[2] Caution should be used when using these estimates. Nationally, the number of uninsured children increased 1 percent from 1995 to 1996 while the *global* number of uninsured in Oklahoma declined 7.3 percent from 615,00 to 570,000. The most recent U.S. Census data (3-year average 1994-1996 CPS) indicates the percentage of uninsured children in Oklahoma under age 19 with income at or below 200 percent of poverty declined 1.6 percent, from 16.9 percent to 15.3 percent. The overall percentage of uninsured under age 18 and below 185 percent of poverty (historically about 14.2%), is not adjusted in the methodology shown above to reflect the decrease in the number of uninsured in Oklahoma. The HCFA 2082 data shows a decline of almost 5,000 enrolled children ages 1-14 from FFY96 to FFY97. The OHCA believes this is due to the "de-linking" of the Medicaid program and the TANF program, which may inadvertently increase the number of uninsured. The data should also be interpreted with care as the number of uninsured may include American Indians who qualify for health services through the Indian Health Service. The CPS questionnaire did not offer respondents the opportunity to report coverage under other government programs than those specified, and the number of uninsured may be overstated.

Number with Insurance		21,705	
Without Insurance			**83,148**
New Eligibles		*95,114*	
Insurance Factor	.	x .569	
Number with Insurance		54,120	
Without Insurance			**40,995**
Total "Uninsured"			**124,143**
rounded			

Participation - As illustrated in Exhibit III, only 67% of the Oklahoma current Medicaid eligibles are enrolled, compared to a national average of 75.4%. (The participation rate is the ratio of the number of enrollees (212,234) divided by the number of eligibles (317,087)). The percentage of Medicaid eligibles who enroll depends on many factors, including attitudes toward welfare and Medicaid, as well as eligibility processing and outreach efforts by the states.

Since July, 1997, the OHCA has initiated some steps to remove some of the barriers to Medicaid enrollment. The OHCA Board passed and the Governor has signed rules to eliminate the assets test; with cooperation from the Department of Human Services, the application form has been simplified (one-page front and back); and the documentation requirements have been reduced. Efforts are continuing for a family-friendly application process (mail-in applications). The OHCA has an outreach campaign ready to begin December 1,1997 which seeks to de-stigmatize Medicaid by stressing that it is an insurance program.

Summary:

In conclusion, the estimates of the number of participants are based on the following assumptions: of the 104,853 ***outreach group eligibles*** who are not enrolled, it is estimated that 27,557 will participate in the program. This will increase the historical participation rate from 67% to 75% (approximations include pregnant women, see Table I).

Of the 95,114 ***new eligibles*** the OHCA made three assumptions. The first assumption is based on a 67% participation rate which would enroll approximately 67,227 new Medicaid eligibles. The second assumption is based on a 75% participation rate which would enroll approximately 74,842 new Medicaid eligibles. The final assumption is based on a 80% participation rate would enroll approximately 80,092 new Medicaid eligibles (approximations include pregnant women, see Table I).

After full implementation of S.B. 639, Phase I and with successful outreach efforts the OHCA expects to enroll between

94,000 and 108,000 additional children out of the pool of 199,967 eligibles. Furthermore, the OHCA expects to enroll between 2,000 and 6,000 newly eligible pregnant women as a result of Phase I expansion.

Attached Tables:

Table I summarizes the above information and goes on to calculate current and new eligible population estimates for the State. It also provides three scenario in which the participation rate estimates for the new eligibles under the expansion are at 67%, 75% and 80%.

Table II presents these same estimates broken down by county and further segmented according to new eligibles, current eligibles and the number of uninsured eligibles.

Table III presents an estimate of the Oklahoma Uninsured population, under 185% of FPL, segmented by age and county.

As stated previously, due to lack of current information on the distribution of the 1996 population by age and county, the historical 1995 distribution was used to estimate the number of new and current eligibles for the expansion, with and without insurance.

1996 POPULATION ESTIMATES

# of Children Under the Age of 18		880,796
48% of Children Under the Age of 18 Have Incomes Below 185% FPL	x	48%
# of Children Under the Age of 18 With Income Below 185% FPL		**422,782**
# of Children Under the Age of 18		880,796
36% Are Eligible Under Current Medicaid Eligibility Guidelines	x	36%
Children Eligible for Medicaid Under Current Elig. Guidelines		**317,087**

PRE-EXPANSION ELIGIBLES/PARTICIPANTS

Children Eligible for Medicaid Under Current Elig. Guidelines		317,087
Current Participation Rate = 67%	x	67%
# of Eligible Children Currently Participating		**212,234**

POST EXPANSION ELIGIBLES/PARTICIPANTS

Outreach "Current Eligibles"

(Increased Participation Rate - From 67% to 75%)

Children Eligible for Medicaid Under Current Elig. Guidelines		317,087
Expected Participation Rate = 75%	x	75%
# of Eligible Children Expected to Participate		**238,473**
# of Eligible Children Expected to Participate		238,473
# of Eligible Children Currently Participating		(212,234)
Increase in Participation due to Outreach		26,239
Plus Increased # of Pregnant Women	+	1,318
Total Current Eligibles Expected to Participate due to Outreach		**27,557**

New Eligibles Up to 185% FPL:

Children Under the Age of 18 With Incomes Below 185% of FPL		422,782
Less: Blind, Disabled		(10,581)
Less: Children Currently Eligible for Medicaid		(317,087)
Total New Eligible Children		**95,115**

67% Participation Rate

New Eligible Children Participating		63,727
Plus New Eligible Pregnant Women	+	3,500
Total New Eligibles Expected to Participate at 67%		**67,227**

75% Participation Rate

New Eligible Children Participating		71,125
Plus New Eligible Pregnant Women	+	3,717
Total New Eligibles Expected to Participate at 75%		**74,842**

80% Participation Rate

New Eligible Children Participating		76,092
Plus New Eligible Pregnant Women	+	4,000

SUMMARY POST EXPANSION:

Scenario #1

Outreach: Increase of Total Current Eligibles Expected to Participate (75% Participation Rate)	27,557
Total New Eligibles Expected to Participate (67% Participation Rate)	67,227
Total Eligibles:	**94,784**

Scenario #2

Outreach: Increase of Total Current Eligibles Expected to Participate (75% Participation Rate)	27,557
Total New Eligibles Expected to Participate (75% Participation Rate)	74,842
Total Eligibles:	**102,399**

Scenario #3

Outreach: Increase of Total Current Eligibles Expected to Participate (75% Participation Rate)	27,557
Total New Eligibles Expected to Participate (80% Participation Rate)	80,092
Total Eligibles:	**107,649**

County	Age Less Than 1 Year	Ages 1-5 Years	Ages 6-14 Years	Cumulative Total Through 14 Years of Age	Ages 15-17 Years	Cumulative Total Through 17 Years of Age
Adair	41	213	430	**684**	134	**818**
Alfalfa	14	73	146	**233**	45	**278**
Atoka	8	42	84	**134**	27	**161**
Beaver	18	92	195	**305**	56	**361**
Beckham	20	105	207	**333**	60	**393**
Blaine	12	62	121	**195**	35	**230**
Bryan	36	184	357	**577**	122	**699**
Caddo	24	121	239	**383**	72	**455**
Canadian	315	1,621	3,212	**5,147**	863	**6,010**
Carter	50	254	500	**804**	150	**954**
Cherokee	50	254	497	**800**	166	**966**
Choctaw	10	53	105	**169**	32	**201**
Cimarron	10	51	104	**164**	31	**195**
Cleveland	601	3,048	5,701	**9,350**	2,035	**11,385**
Coal	5	24	49	**77**	15	**92**
Comanche	227	1,120	1,869	**3,216**	636	**3,851**
Cotton	12	64	130	**207**	39	**246**
Craig	32	164	322	**518**	104	**622**
Creek	182	931	1,799	**2,912**	546	**3,458**
Custer	58	299	582	**940**	201	**1,141**
Delaware	48	248	493	**789**	155	**943**
Dewey	12	63	132	**207**	35	**242**
Ellis	9	45	100	**154**	30	**183**
Garfield	116	595	1,166	**1,877**	338	**2,215**
Garvin	40	206	424	**670**	131	**800**
Grady	79	410	825	**1,315**	246	**1,561**
Grant	17	85	163	**264**	47	**311**
Greer	4	20	40	**64**	13	**77**
Harmon	2	12	25	**39**	7	**46**
Harper	11	60	127	**198**	37	**235**
Haskell	12	61	124	**196**	39	**235**
Hughes	10	54	113	**178**	36	**213**
Jackson	80	394	653	**1,128**	187	**1,315**
Jefferson	4	20	42	**66**	13	**79**
Johnston	9	49	102	**161**	35	**195**
Kay	98	501	970	**1,569**	287	**1,856**
Kingfisher	37	190	385	**612**	109	**721**
Kiowa	29	64	107	**200**	45	**245**
Latimer	6	33	67	**106**	23	**129**
LeFlore	66	341	672	**1,079**	212	**1,291**
Lincoln	61	317	641	**1,020**	195	**1,215**

Logan	63	325	650	**1,037**	250	**1,288**
Love	14	72	146	**232**	47	**279**
Major	62	324	661	**1,047**	187	**1,234**
Marshall	24	126	247	**397**	83	**480**
Mayes	32	163	322	**516**	98	**614**
McClain	22	112	231	**365**	72	**437**
McCurtain	11	58	115	**184**	35	**219**
McIntosh	72	373	764	**1,209**	240	**1,449**
Murray	16	85	175	**276**	53	**329**
Muskogee	96	494	988	**1,578**	300	**1,878**
Noble	26	134	268	**427**	76	**504**
Nowata	18	94	187	**299**	58	**357**
Okfuskee	15	75	151	**240**	48	**289**
Oklahoma	1,145	5,678	9,771	**16,595**	2,888	**19,483**
Okmulgee	18	101	220	**340**	132	**472**
Osage	82	457	1,021	**1,560**	577	**2,137**
Ottawa	14	78	169	**261**	111	**371**
Pawnee	28	158	346	**532**	202	**734**
Payne	108	549	1,047	**1,704**	454	**2,158**
Pittsburg	52	272	554	**879**	172	**1,051**
Pontotoc	44	226	449	**719**	152	**871**
Pottawatomie	71	370	754	**1,196**	265	**1,460**
Pushmataha	7	37	73	**117**	23	**140**
Roger Mills	8	43	89	**141**	26	**167**
Rogers	216	1,113	2,202	**3,531**	654	**4,184**
Seminole	16	81	164	**260**	50	**310**
Sequoyah	58	296	587	**941**	183	**1,125**
Stephens	69	358	724	**1,151**	214	**1,366**
Texas	46	238	478	**762**	153	**914**
Tillman	10	51	104	**165**	31	**196**
Tulsa	1,485	7,352	12,597	**21,434**	3,658	**25,092**
Wagoner	142	744	1,551	**2,437**	457	**2,894**
Washington	80	444	973	**1,498**	552	**2,049**
Washita	13	68	136	**217**	39	**256**
Woods	16	84	166	**267**	59	**326**
Woodward	20	106	214	**341**	62	**403**
All counties	6,698	33,881	63,312	**103,891**	20,252	**124,143**
	59,524	228,347	448,696	**736,566**	144,230	**880,796**
	1995 Estimates					
	6,459	32,585	60,841	**99,885**	19,558	**119,443**
	57,043	218,829	429,994	**705,866**	138,218	**844,084**

	7%	26%	51%	**84%**	16%	
	11%	15%	14%	**14%**	14%	**0**

NOTE: The individual County-specific numbers in this chart will vary slightly from previous presentations. This is due to the "rounding" of numbers by the Excel Application when performing multiple calculations.